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F 000	INITIAL COMMENTS Surveyor: 10573 This was a recertification survey conducted at Wisconsin Veterans Home Stordock from 3/30 - 4/2/14. # of federal citations issued: 5 The most serious citation is F441 cited at a scope/severity level of E (potential for harm/pattern). Census: 197 Sample size: 30 Supplemental sample size: 5 Survey coordinator: #10573	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 29173 Based on observations, medical record review and staff interviews, the facility did not promote care in a manner which enhances each residents dignity and respect and in full recognition of his or her individuality for 2(member #9 and #2) of 11 sampled members. Member #9's Foley catheter bag was observed to	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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be uncovered and visible from the hallway.

The facility had posted 3 bold printed 8 by 12 sheets of bright yellow paper which included personal health information regarding member #2. One of the signs was posted on the closet door in full view of the hallway.

Findings include:

The facility's policy titled, "Foley Catheter Care and Use of Legband Foley Catheter Strap," revised on March 2012 indicated, "...bedside drainage bags shall be covered with a cloth bag when a member is out of their room and/or if the bag is visible from the door to the member's room..."

1. Member #9 was admitted to the facility with diagnosis that included, urine retention and failure to thrive.

On 3/30/14 at 8:30 a.m. surveyor #29173 observed member #9 laying in bed. The Foley catheter bag was uncovered, hanging on the bed frame facing the door, and was visible from the hallway. Surveyor #29173 noted the catheter bag contained a yellow liquid substance.

On 3/30/14 at 11:00 a.m. surveyor #29173 observed member #9's uncovered catheter bag was hanging on the side of the bed facing the door, and was visible from the hallway.

On 3/30/14 at 3:40 p.m. surveyor #29173 observed member #9 laying in bed. The Foley catheter bag was hanging on the side of the bed facing the door uncovered, and was visible from the hallway.

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F 241	Continued From page 2 On 3/31/14 at 10:05 a.m. surveyor #29173 observed member #9's uncovered catheter bag was hanging on the bed frame facing the door, and was visible from the hallway. Surveyor #29173 noted the catheter bag contained a yellow liquid substance. On 3/31/14 at 11:05 a.m. surveyor #29173 observed Member #9's uncovered catheter bag was hanging on the side of the bed facing the door, and visible from the hallway. On 3/31/14 at 11:10 a.m. surveyor #29173 shared the above findings with RN (Registered Nurse)-F. RN-F stated, "the Foley catheter bag should be covered...it is a dignity issue...I will make sure the Foley bag is covered". On 3/31/14 at 3:00 p.m. surveyor #29173 observed member #9's Foley catheter bag was hanging on the side of the bed frame, and was covered with a cloth bag. Surveyor: 21654 The facility's HIPPA (Health Insurance Portability and Accountability Act) policy dated 9/12 indicated that the facility shall identify the employees who need access to PHI (Personal Health Information) according to the categories of uses for treatment, payment or health care operations. The facility shall determine the circumstances under which employees may use PHI. All volunteer and member help shall be given the minimum amount of PHI necessary to do their job. 2. On 3/30/14 at 11:00 a.m., surveyor #21654 walked by member #2's room and noted a bright yellow 8 by 12 sheet of paper taped to the	F 241		

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F 241	Continued From page 3 member's closet door with bold black lettering stating, "Do NOT put Pull-ups or Briefs on me. I am ALLERGIC! Use "Fit Right" Brief! No Briefs at Night!!" The surveyor could clearly view the sign from the hallway. The surveyor entered the member's room and noted two more exact signage; one posted in an upright position on the member's night stand, and one posted on the member's bathroom door. The posting was signed by LPN (Licensed Practical Nurse)-M. The surveyor immediately notified RN (Registered Nurse)-K regarding the PHI posted in member #2's room in full view for non direct care staff, volunteers and visitors. On 3/31/14 at 7:30 a.m., surveyor #21654 again walked by member #2's room and noted the same above signage now posted in an open closet in full view from the hallway, on the member's bathroom door and on the wall in the member's room near a book case. The surveyor immediately interviewed RN-K. RN-K stated, "I misunderstood and thought only the sign on the closet door needed to be non viewable".	F 241		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Surveyor: 21654	F 312		

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Based on observations, staff interview and record reviews, 1 (member #2) of 12 observations of member care, who were unable to carry out activities of daily living had not received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

Member #2 was assessed to be frequently incontinent of bowel and bladder and required extensive assistance from staff to perform personal hygiene. After an incontinent episode of urine, staff had not thoroughly cleansed the member's perineal areas per the facility policy.

Findings include:

The facility's policy entitled "Perineal Care" last revised 4/11 indicated the facility followed the text published in 2007 by Gerlach and Hegner entitled "Assisting in Long-Term Care" sixth edition. The text indicated for male perineal care, the following steps were to be completed to accomplished;

* Have resident flex and separate knees. Note: If the resident is unable to spread legs and flex knees, the perineal area can be washed with the resident on the side with legs flexed. This position provides easy access to the perineal area.

* Make a mitt with wash cloth and apply a small amount of soap.

* Grasp penis gently with one hand and wash. Begin at the meatus and wash in a circular motion toward the base of the penis.

* If resident is not circumcised, draw foreskin back. Be sure entire penis is washed. Rinse

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thoroughly.

* Wash scrotum. Lift scrotum and wash perineum.

* With a new washcloth, remake mitt, and rinse area just washed.

* Pat dry washed area with towel. Reposition foreskin.

* Turn resident away from you. Flex upper leg slightly if permitted.

* Make a mitt, wet, and apply soap.

* Expose anal area. Wash area, stroking from perineum to coccyx.

* Rinse with in the same manner. Pat dry carefully.

Member #2's most recent MDS (minimum data set) dated 2/5/14 indicated the facility had assessed the member to be frequently incontinent of bowel and bladder and required extensive assistance from staff to perform personal hygiene.

The member had a plan of care dated 11/22/12 which was last reviewed on 2/17/14 to include an intervention for staff to provide peri-care after each incontinent episode. The member also had a plan of care relating to behaviors dated 8/8/13 with interventions listed including explain what is being done to member/reorient, and provide reassurance regarding cares.

Review of the member's documented target

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behaviors from 12/28/13 through 3/23/14 indicated the member would scream/yell/curse during cares, when in his room, and when in the dining room.

On 3/30/14 at 1:20 p.m., surveyor #21654 observed CNA (Certified Nursing Assistant)-L perform perineal care for member #2 after an incontinent episode of urine. Throughout the cares, the member only yelled out once when staff attempted to remove a pillow from under his right shoulder blade, otherwise, the member was in bed during the provision of the cares and remained quiet and cooperative throughout the care observation. It was noted by the surveyor that member #2 was uncircumcised. CNA-L cleansed the resident frontal groin folds with a wet wipe, turned the member onto his right side, and cleansed the resident buttocks and rectal areas with a wet wipe, placed a clean brief on the resident, placed a blue heel boot on the member's right foot, covered the resident with a sheet and blanket, placed an alarmed mat at the bedside and was exiting the room when the surveyor asked her what the facility's directive was regarding through perineal care after incontinence. CNA-L stated, "We are to clean the front groin folds, buttocks and rectum. He got total perineal care when he got up this morning". When the surveyor questioned CNA-L regarding the observation of the absence of thorough pericare for member #2 to include pulling back foreskin, cleansing meatus and penile shaft, and lifting the scrotum to cleanse, CNA-L stated, "He (#2) will scream if I pull back his foreskin. I let him relax first then come back and do the foreskin. That isn't on his plan of care in the room but I write that on a cheat sheet to let others know how to care for him. The plan of care

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F 312	Continued From page 7 doesn't always get updated. This is what I do with him. Maybe he reacts differently with other staff". CNA-L had not followed the facility's policy regarding through perineal care for member #2 after an incontinent episode of urine. On 3/30/14 at 1:45 p.m., surveyor #21654 interviewed RN (Registered Nurse)-K. RN-K stated, "If he (#2) consistently gets upset during pericare, I am not aware of that. It should be on his plan of care if that is the case. His behavior is yelling out, not refusing cares. He yells out randomly even when he is just sitting in the dining room. Yelling out doesn't mean he is refusing cares. We have a stop and watch tool and staff are to fill this out if they identify an important change while caring for members. I haven't received one for him (#2) regarding overt behaviors with pericare". On 3/30/14 at 1:50 p.m., surveyor #21654 interviewed CNA-N. CNA-N stated, "He (#2) does not yell when I do his pericare and pull back his foreskin. He is usually okay during perineal cares. If he yells out, I ask him what is wrong, and he usually only yells out when you are cleansing his buttocks because it is sore, and never yells out when you cleanse his penis and pull back the foreskin".	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314		

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pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Surveyor: 21654

Based on observations, staff and resident interviews, record review, and comprehensive assessment of the resident, the facility had not ensured that 2 (member #1 and #2) of 18 members reviewed for pressure ulcer risk who entered the facility without pressure ulcer did not develop pressure ulcers.

Member #1 was assessed by the facility to be at high risk for the development of pressure ulcers. Braden scores for the development of pressure ulcers completed weekly upon the members admission indicated increasing risk for the development of pressure ulcers. The facility would initiate additional interventions relating to pressure ulcer prevention after each Braden score was assessed, but the facility had not developed an effective plan of care intervention to protect the member's heels from pressure. Ultimately, the member developed an avoidable stage II pressure ulcer to the left heel. When the pressure ulcer presented, licensed staff had not completed a through assessment to include the characteristics of the wound and wound bed, and measurements Additionally, the resident required the use of continuous oxygen delivery via nasal cannula when in bed. The facility had not developed a care plan intervention to prevent pressure to the areas where the oxygen tubing came in contact with the upper ear and the skull

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bone. The member developed indentations and redness to the ears which required a physicians order to apply skin prep to bilateral behind ears to the reddened areas for protection.

Member #2 was assessed by the facility to be at high risk for the development of pressure ulcers. The resident had a remote history of stage III pressure ulcer to the right hip. The member had declined in his ability to be independently mobile. The member had a care plan intervention in place to include float heels off mattress with pillow, if member allows. Staff were aware the member would often kick out the pillow when placed to free float heels, but this was not documented or communicated to the unit nurse for reevaluation of a more effective method to accomplish free floating of heels. As a result, the member developed an avoidable unstageable pressure ulcer to the left heel. Additionally, when the pressure ulcer presented, licensed staff had not completed a through assessment to include the causative factor of the development of the pressure ulcer, characteristics of the wound and wound bed, and measurements of the wound. Findings include:

The NPUAP (National Pressure Advisory Panel) serves as the authoritative voice for improved resident outcomes in pressure ulcer prevention and treatment through public policy, education and research. The 2009 NPUAP Position paper on "Staging Pressure Ulcers" indicated, "Differentiating pressure ulcers from other wound etiologies is within the domain of RN's (Registered Nurses). As per the Scope and Standards of Nursing Practice detailed in the statement from ANA (American Nurses Association) president, Rebecca M. Patton, "RN's

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are expected to assess the patient's skin, stage the wound and implement an individualized plan of care based on the patient needs. In order to facilitate accurate diagnosis of any skin lesion, education of nurses to be able to accurately identify the anatomical location of a wound and its cause is vital."

The NPUAP's Quick Reference Guide published in 2009 entitled "Pressure Ulcer Prevention" indicates to ensure that the heels are free of the surface of the bed. Heel protection devises should elevate the heel completely (offload them). Develop and implement a prevention plan when individuals have been identified as being at risk of developing pressure ulcers. Risk factors identified in a risk assessment should lead to an individualized plan of care to minimize the impact of those variables. High pressures over bony prominence's, for a short period of time, and low pressures over bony prominence's, for a log period of time, are equally damaging. In order to lessen the individual's risk of pressure ulcer development, it is important to reduce the time and the amount of pressure he/she is exposed to. Consider individuals who are bedfast and/or chairfast to be at risk of pressure ulcer development.

The Quick Reference Guide list above categorizes a stage II pressure ulcer as partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. An unstageable pressure ulcer is categorized as full thickness skin or tissue loss in which actual depth of the ulcer is completely obscured by sough and/or eschar in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the

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F 314	Continued From page 11 true depth cannot be determined; but it will be either a stage III or IV. The NPUAP article entitled "Medical Device Related Pressure Ulcers: The Hidden Epidemic Across the Lifespan" published in 2012 indicates medical device related pressure ulcers are defined as localized injury to the skin or underlying tissue as a result of sustained pressure from a device)e.g., nasal cannula tubing, braces, splints, oxygen face masks, prosthesis, etc). Tissue injury typically mimics the device shape which tend to progress rapidly as they often occur over areas without adipose tissue. Medical device related pressure ulcers occur due to tight securement, poor positioning or fixation of device, inappropriate size; skin obscured from visualization, lack of awareness of edema impact, failure to check tubing, lack of awareness of need to remove, reposition and provide basic care to skin under device, lack of best practice guidelines and lack of standardized practice. 70% of medical device related pressure ulcers occur on the head, neck or face (ears 37% with use of nasal cannula of which are located behind the ear or at the mandible) of which 74% were not identified until they were stage III or Iv or unstageable. 63% had no documentation of device removal every shift, pressure relief or skin inspections. Prevention for medical devise related pressure ulcers with use of oxygen nasal cannula include to inspect skin under and around tubing at least every 8-12 hours, educate patients/family to inform staff of discomfort, clearly assign responsibility for assessment, document findings, use ear protectors on tubing (intervene early), check strap tension and stock ear protectors close to nasal cannula.	F 314		

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The facility's Skin and Wound Care Documentation policy, dated 4/11 indicated initial evaluation of a member's wound shall be documented in member progress notes. Shall include complete description of findings including measurements, condition of peri wound, condition of wound bed, percentage and type of tissue, type/amount of drainage, presence or absence of odor.

1. Member #1 was admitted to the facility on 1/29/14 with diagnosis to include diabetes, cerebral vascular accident, extensive vascular disease, chronic low back pain, chronic obstructive pulmonary disease and obesity.

The member's only MDS (minimum data set) dated 2/6/14 indicated the facility assessed the member to require extensive assistance to transfer and perform bed mobility, could ambulate in room with extensive assist from staff, and was occasionally incontinent of bowel and frequently incontinent of bladder.

The facility conducted weekly Braden Scores for the Prediction of Pressure Ulcer risks for the member weekly with the following documented results:

* 1/29/14. Score 10. High Risk. (The lower the score, the higher the risk). Increase body check to twice per week. Use of pads and briefs. Reposition every two hours with assistance. Use mild skin cleanser and barrier cream.
* 2/5/14. Score 11. High risk. Add routine toileting, specialized foam mattress to plan of care.
* 2/12/14. Score 9. High risk. Add specialized

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chair cushion-own foam.
* 2/19/13. Score 9. High Risk. Add ROHO cushion to chair.
* 2/26/14. Score 7. High Risk. No change in plan of care.

The member's care plan and personalized member care card (utilized by direct care staff) did not indicate an intervention to prevent pressure to the resident's heels.

Documentation in the member's medical record dated 2/28/14 indicated RN-O noted an unstageable pressure wound to the left lateral heel. The documentation indicated the possible cause was, "pillow moved from floating heels". The documentation did not indicate size or description of wound and surrounding tissue. A Podus boot was placed on the member's left foot and a wound team consult was initiated. The member's plan of care was updated on 2/28/14 to also include use of heel Medix bot to right foot and leg when in bed, hold Ted stockings to left lower extremity, and use of an air mattress.

On 4/1/14 at 9:30 a.m., DON- G verified to surveyor #21654 that free floating of heels was not an intervention listed on member #1's care card or personalized member care card. DON-G also verified it was the facility's standard to free float heels for member's assessed to be at risk for pressure ulcer development and stated, "The CNA's (Certified Nursing Assistants) aren't documenting refusal of him (#1) to free float heels or that the pillows weren't effective. If the RN had known, it would have triggered a behavior in the computer regarding this. We have initiated a start/stop tool for CNA's to fill out for better communication to licensed staff a month or so

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ago".

On 4/2/14 at 7:25 a.m., surveyor #21654 interviewed RN-O via the telephone. RN-O stated, "I found the pressure ulcer on his (#1) heel. The day staff told me about it and when I went into the room, he had a pillow under his leg but had moved it up toward his knee so his heels weren't free floating. He can move his legs really well in bed. I'm not sure if this was an issue before but he was moving his feet around in the bed a lot during my assessment. The wound was brown and softer like a blood blister. I thought I measured it and we are to be more descriptive about the wound in our initial charting. I didn't talk to the staff to see if it is typical for him to move the pillow. Night staff round on him every 2 hours and a wound like that probably didn't happen over a two hour span of time.

On 4/2/14 at 8:15 a.m., surveyor #21654 interviewed RN-K. RN-K verified to the surveyor that member #1 was actively moving his lower extremities while in bed prior to the development of an unstageable pressure ulcer to the left heel. RN-K stated, "He just doesn't like to turn onto his side so staff have to assist him with bed mobility".

On 3/30/14 at 8:55 a.m., surveyor #21654 observed member #1 lying in bed with oxygen being delivered via nasal cannula. The surveyor noted that the oxygen tubing had no padding at the ear/skull area. CNA-L verified to the surveyor that the member had no padding on his oxygen tubing behind his ears and examined the ears noting red dents behind both ears, the left ear was blanchable, but the right ear had a small area in the center that did not blanche to digital pressure. The resident indicated, "Behind my

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ears are sore".

Review of the resident's TAR (treatment administration record) indicated that skin checks were being completed twice weekly with no new findings. The TAR indicated the use of oxygen for the resident but did not indicate licensed staff were to ensure use of padded oxygen tubing for member #1.

On 3/30/14 at 9:15 a.m., surveyor #21654 interviewed RN-K. RN-K indicated that the night CNA's change oxygen tubing twice a week on Monday and Thursday and the last time member #1's oxygen tubing was changed would have been Thursday (3/27/14). RN-K indicated that staff are instructed to provide padding on oxygen tubing at the ears when tubing is changed twice weekly.

On 3/30/14 at 9:20 a.m., surveyor #21654 observed member #1 lying in bed with padding at bilateral ears around oxygen tubing. At 9:40 a.m., the resident was observed to be up in a chair without his oxygen on. At that time, RN-K verified to the surveyor that behind both ears were red but blanchable. A physician's order dated 3/30/14 at 10:26 located in the resident's medical record indicated "skin prep barrier to bilateral behind ears reddened areas daily (protection).

2. Resident #2 had diagnoses to include diabetes, dementia, neuropathy, anemia, and coronary artery disease.

The member's medical record indicated that on 11/12/12, the resident was independent in ambulation. On 1/21/13, the member's mobility status was listed as per wheel chair only.

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The resident's most recent MDS dated 2/5/14 indicated that the resident was assessed to require extensive assistance from staff to transfer and perform bed mobility, required extensive assistance from staff to ambulate in room, and was frequently incontinent of bowel and bladder.

The resident's Braden Score for the Prediction of Pressure Ulcers dated 2/13/14 indicated a score of 10 and was assessed to be at high risk for the development of pressure ulcer. A plan of care intervention included "elevate heels off mattress". The members plan of care was updated on 7/21/13 to include, "float heels off mattress with pillow, if member allows". No staff documentation in the member's medical record indicated that the resident had refused free floating of heels or that he was kicking out the pillows preventing free floating of heels.

On 3/9/14, RN-P documented a skin event in member #2's medical record that indicated, "Pressure ulcer-stage 2 left heel. Possible causes: Pressure. New intervention: Prevelon boot to both feet at all times". The documentation did not indicate size or description of wound and surrounding tissue.

On 3/30/14 at 11:00 a.m., surveyor #21654 interviewed CNA-L. CNA-L was one of member #2's usual caregivers. CNA-L stated, "We do put his feet up on pillows, but he would kick them out. He moves around a lot in bed. I noticed that when we changed him to wearing blue boot, when I come in in the morning he had those boots kicked off. He hates hot feet when he is sleeping. I told the night shift to try to keep his feet uncovered, but staff don't always leave his

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feet uncovered and I think he would just kick the boots off because he was too hot". They did eventually get a new black boot for his left foot that stays on".

On 3/30/14 at 12:40 p.m., surveyor #21654 interviewed RN-K. RN-K stated, "I was not aware that he (#2) was kicking out the pillows prior to us noticing the stage II pressure ulcer on his left heel".

On 3/30/14 after discussions with surveyor #21654, the facility updated member #2's care plan to include, "know that I often will kick pillows or my boots on my feet off when in bed. Please encourage use and reapply if I allow. Update RN if I refuse".

On 3/31/14 at 8:00 a.m., surveyor #21654 interviewed RN-P via the telephone. RN-P stated, "I assumed that because he (#2) kicked out the pillow from under his feet, the wound was due to pressure. I was assessing him and noticed that his feet were not free floating on a pillow. I asked him if I could put a pillow under his legs and he refused. He is supposed to be free floating on a pillow and every time you went into the room his feet had been off the pillow. I'm not sure if he had been consistently doing that, but I talked to the aides about his heels. They said he is anxious and moves around in bed and kicks out the pillows. I told them things like this need to be reported so we can change the plan of care. They check on him every 2 hours during the night and sometimes his heels would be free floating, and other times they were not. We put boots on him now at night".

On 3/31/14 at 8:05 a.m., surveyor #21654

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F 314	Continued From page 18 interviewed DON (Director of Nursing)-G. DON G verified to the surveyor that the nurse who discovers a pressure ulcer is to determine the cause and document a total assessment of the wounds characteristics.	F 314		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 27892 Based on observation, interview, and record review, the facility did not ensure pharmaceutical services were provided to meet the needs of 2 (resident #31 and #32) of 3 residents observed	F 425		

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during the administration of inhaled medications.

Staff did not instruct or offer resident #31 and resident #32 to rinse their mouths with water after the administration of inhaled medications where the physician's orders and medication manufacturer indicated this was required.

Findings include:

According to the manufacturer's specifications dated 5/2012 (provided by the facility), patients should be directed to rinse their mouths with water and spit the water out after inhaling Symbicort to prevent oral and pharyngeal Candida albicans infections.

1. According to the current physician's orders dated 2/28/14, resident #31 was to receive two inhalations of Symbicort twice a day and "RINSE WELL AFTER and spit several times after each use".

On 4/1/14 at 7:15 a.m. surveyor #27892 observed LPN (Licensed Practical Nurse)-C administer Symbicort inhalations to resident #31. LPN-C prepared the inhaler and administered one inhalation to the resident. LPN-C waited approximately two minutes and administered a second inhalation to the resident. LPN-C then walked away from the resident and replaced the medication in the medication cart without instructing or offering the resident water to rinse their mouth.

2. According to the current physician's orders dated 3/31/14, resident #32 was to receive two inhalations of Symbicort twice each day and "rinse mouth after use".

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F 425	Continued From page 20 On 4/1/14 at 8:05 a.m. surveyor #27892 observed LPN-C administer Symbicort inhalations to resident #32. LPN-C prepared the inhaler, administered one inhalation of the medication to the resident and waited approximately one minute before administering a second inhalation. LPN-C told the resident "thank you", walked away from the resident, and placed the medication in the medication cart. LPN-C did not offer or instruct the resident to rinse their mouth with water after administration of the medication. On 4/1/14 at 8:35 a.m. LPN-C verified to surveyor #27892 resident #31 and resident #32 should have been instructed or asked to rinse their mouths with water and spit the water out after inhaling the Symbicort.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		

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F 441	Continued From page 21 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 27892 Based on observation, interview, and record review, the facility did not ensure staff used appropriate hand hygiene procedures to assist in infection prevention for 2 (member #14 and #7) of 12 members observed during the provision of cares where hand hygiene was indicated. Additionally, the facility had not established an infection control program to prevent the spread of infections during an outbreak of Norovirus which had the potential to affect all 50 members residing on the 200 unit in a building with a census of 197. Staff did not remove gloves and perform hand hygiene when gloves gloves became soiled and	F 441		

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prior to touching clean items in resident #14's room.

Staff did not perform hand hygiene when gloves became soiled and prior to touching clean items in member #7's room.

An outbreak of suspected Norovirus presented on 10/27/13 on the 200 unit of the facility which housed 50 residents. The facility had not recognized the outbreak until 10/28/13 and all departments were not aware of outbreak prevention strategies to prevent spread of infection until 24 hours after the suspected outbreak had occurred. The facility had not ceased group activities and group dining for well members when additional members continued to display signs and symptoms of Norovirus. 1 CNA (Certified Nursing Assistant), who had permanent assignment to the 200 unit, had presented with signs and symptoms of Norovirus, but was allowed to return to work prior to 48 hours after symptoms ceased. 9 more members who resided on the 200 unit developed symptoms after the CNA returned to work. The facility's policy indicated that group activities and dining could continue involving symptom free members, which is not in keeping with the standard of practice, when additional members continued to display symptoms of the virus. As a result, 21 of 50 members presented with signs and symptoms of GE (gastroenteritis) on the 200 unit.

Findings include:

Review of the facility's policy and procedure last reviewed on August 2012 stated "Hand washing/hand hygiene shall be performed before & after direct member contact, after removing

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gloves, using the restroom, handling/serving food, handling and/or contact with contaminated or potentially contaminated equipment or articles, after blowing your nose, putting you hand to face with sneezing or coughing and after smoking. Wearing gloves shall not be a substitute for hand hygiene."

1. According to the MDS (Minimum Data Set) dated 2/28/14, resident #14 required extensive assist for personal hygiene and was frequently incontinent of bowel and bladder.

On 3/30/14 at 1:45 p.m. surveyor #27892 observed CNA (Certified Nursing Assistant)-A and CNA-B provide incontinence care to resident #14 while the resident was in bed. Both CNA's performed hand hygiene and donned disposable gloves. CNA-B removed the resident's wet brief and CNA-A used disposable wipes to provide pericare to the resident's urethral and groin areas. CNA-A removed the soiled gloves, but without performing hand hygiene, CNA-A opened a drawer to the resident's nightstand and removed a package of disposable gloves. CNA-A then used hand sanitizer and donned disposable gloves. Both CNA's rolled the resident and CNA-A used disposable wipes and cleansed the resident's rectal and buttock areas. CNA-A then removed the soiled gloves and without performing hand hygiene touched the resident's bedding and clean sheets on the bed.

On 4/4/14 at 10:25 a.m. surveyor #10573 interviewed DON (Director on Nursing)-G. When asked what expectations would be of a caregiver wearing gloves while doing personal cares, DON-G stated she would expect the caregiver to use hand gel or wash hands after removing

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gloves and before proceeding with cares.
Surveyor: 29173

2. According to the MDS dated 3/24/14, member #7 required extensive assist for personal hygiene and was frequently incontinent of bowel and bladder.

On 3/31/14 at 8:00 a.m. surveyor #29173 observed CNA-D and CNA-E toilet and provide care to member #7. Both CNAs performed hand hygiene and donned disposable gloves. CNA-D used disposable wipes to provide pericare to the resident's urethral and groin areas. CNA-D removed the soiled gloves, without performing hand hygiene, CNA-D donned disposable gloves, picked up a urine soaked incontinent pad, threw it in the garbage, and removed her gloves. Without performing any type of hand hygiene, CNA-D donned disposable gloves, and touched the member's clothing, call light, television remote, ceiling lift, wheelchair and bedding.

Surveyor: 21654
NOROVIRUS OUTBREAK

The facility's policy entitled Infectious Gastrointestinal Illness (Including Norovirus) dated 5/13 indicated a case definition for possible Norovirus included both criteria must be met; either of the following; Diarrhea; 3 or more liquid or watery stools above what is normal for the resident within a 24 hour period or Vomiting: 2 or more episodes in a 24 hour period and a stool specimen positive for Norovirus. An outbreak of viral gastroenteritis should be suspected when two or more members and/or staff develop new onset of vomiting and/or diarrhea within one to two days. When a clinical outbreak is detected,

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Public Health authorities shall be contacted by the Medical Director or designee. The Medical Director, Infection Control Practitioner, Nursing Supervisors or Licensed nurse in charge may place a unit on restrictions. Staff calling in for the sudden onset of the identified gastrointestinal symptoms may not return to work until symptom free for 48 hours. Licensed staff instruct staff and members that hand hygiene with soap and running water is recommended for this virus. Instruct all clinical staff and Housekeeping regarding diligent cleansing of symptomatic member rooms and other frequently touched surfaces. Notify dietary of any changes regarding meal service. Notification to dietary of any changes regarding meal service would be done by 2:30 p.m. for restrictions to start /end with breakfast the following day; before 8:15 a.m. for restrictions to start/end with noon meal; and notification before 11:15 a.m. for restrictions to start/end with evening meal. A building announcement via overhead system is made by building nursing supervisor or designee notifying all member and staff that a unit/building is being restricted. The members from the restricted unit/building are requested not to attend campwide functions or work therapy. Persons making the decision to restrict sends out e-mail to all King staff immediately regarding the restrictions. This is especially important on the weekends. Nursing staff put up signage alerting other that the unit(s) is on restrictions. Activities and social functions may be canceled on a building or camp wide basis. Adaptation in activities: small supervised activities; individuals with gastrointestinal symptoms are asked to leave the activity; held in open spaces if possible;minimize or eliminate interpersonal contact of passing objects; food is not served in

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ways which members share common utensils, finger foods etc; disposable or cleanable equipment is used for the activity. Equipment is cleaned and disinfected after use. Activity modification and/or cancellation within a building are managed through collaboration between the Medical Director and Nursing Administrator, especially in the face of a high velocity outbreak. Table cloths are removed from the dining table during an outbreak to avoid cross contamination. Staff feed only one member at a time and wash their hands in between. members with symptoms are placed in contact/droplet precautions and restricted to their rooms immediately while the licensed staff determines if they meet the case definition. When a unit has been placed on restrictions, laundry workers shall wear masks when sorting member's laundry from that building.

On 4/1/14 at approximately 7:30 a.m., surveyor #21654 reviewed the facility's member line list regarding GI (gastrointestinal) illness and noted that on 10/25/13, member #33 presented with 3 loose stools, nausea and chills. The member tested positive for Norovirus per stool sample on 11/1/13. Member #33 resided on the B wing of the 200 unit. On 10/26/13, resident #24 present with 3 loose stools, 1 episode of vomiting, nausea, chills and abdominal cramping. Member #24 resident on the B wing of the 200 unit. On 10/26/13, member #35 presented with 5 loose stools. Member #35 resided on the C wing of the 200 unit. On 10/27/13, member #34 presented with 2 episode of vomiting and 9 loose stools. Member #34 resident on the B wing of the 200 unit. On 10/27/13, CNA-J presented with nausea, vomiting, diarrhea and fever. CNA-J is assigned to the 200 unit of the facility. By the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52A223	A. BUILDING _____ B. WING _____	04/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI VETERANS HM STORDOCK 700	N2665 CTY RD QQ KING, WI 54946

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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criteria, a suspected GI outbreak would have occurred on 10/27/13. From 10/27/13-11/4/13, 17 additional members residing on the 200 unit presented with signs and symptoms of GE (gastroenteritis). A total of 3 members tested positive for Norovirus. A total of 9 staff who were assigned to work on the 200 unit presented with signs and symptoms of GE from 10/27/13-10/30/13.

Review of the initial notification of the outbreak form indicated the outbreak of GE was reported to the Health Department on 10/28/13 (Monday). The initial notification of investigation form indicated the onset of GE outbreak date was 10/27/13 (Sunday).

On 4/1/14 at 8:00 a.m., surveyor #21654 interviewed DON (Director of Nursing)-G. DON-G functions as the facility's Infection Preventionist. DON-G stated, "Per our policy, 10/27/13 would be defined as suspected Norovirus outbreak. That was a Sunday. We didn't put measures into place until 10/28/13 (Monday) when I got into work. That's when we quarantined the 200 unit, which was 24 hours after the fact. Emails were sent out to the Medical Director, campus DON's and ADON's (Assistant Director of Nursing), to the Commandant, laundry, and to all campus staff the morning of 10/28/13. We sent an email to the kitchen on 10/28/13 at 8:04 a.m. to initiate arrangements for the 200 unit members to eat on the unit related to the GI restrictions. When members presented with signs and symptoms, they were immediately placed in precautions and ate in the door ways to their room. Isolation of the entire 200 unit was initiated on 10/28/13. Signage regarding the outbreak was also posted the morning of 10/28/13".

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	52A223	A. BUILDING _____ B. WING _____	04/02/2014

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On 4/1/13 at 11:00 a.m., surveyor #21654 interviewed AT (Activity Therapist)-H. AT-H stated, "People that weren't sick on the 200 unit we continued to engage in group activities. We only engaged those who were already in the dining room area (of the 200 unit). We had coffee and talks and games but would clean and wipe off equipment and not let them share dice (for example). I was told that initially with the start of illness, we can do group activities. I know we were on high alert as more people became sick". Group activities continued on the 200 unit in lieu of the number of members which continued to present with signs and symptoms of GE and in lieu of known outbreak of Norovirus per laboratory analysis on 11/1/13.

On 4/1/13 at approximately 11:30 a.m., surveyor #21654 reviewed the staff line list for GI illness and noted that CNA-J who was assigned to the 200 unit, presented with nausea, vomiting, diarrhea and fever on 10/27/13. The well date was listed as 10/29/13, and the return to work date was listed as 10/30/13. The facility's policy regarding 48 hour time period from well date to return to work date had not been implemented for CNA-J. A total of 9 members residing on the 200 unit presented with signs and symptoms of GE from 10/30/13-11/4/13.

On 4/1/13 at 12:00 p.m., surveyor #21654 again interviewed DON-G. DON-G stated, "We educated staff regarding enhanced hand hygiene on 10/28/13. Well members on the 200 unit continued to eat together in the 200 unit dining room. She (CNA-J) has a permanent assignment to the C wing of the 200 unit, but would float to answer call lights and help other staff to the A and

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	52A223	A. BUILDING _____ B. WING _____	04/02/2014

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F 441	Continued From page 29 B units also. She (CNA-J) was allowed to return to work before 48 hours had lapsed from well date to return to work date". A total of 21 of 50 members residing on the 200 unit presented with signs and symptoms of GE.	F 441		